Operating Engineers’ Local No. 428 Health & Welfare Trust Fund

P.O. Box 43110, Phoenix, AZ 85080-3110
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SHORT TERM DISABILITY INCOME CLAIM FORM

PART A EMPLOYEE'S STATEMENT *(MUST BE COMPLETED BY EMPLOYEE)*

1. EMPLOYEE NAME (PLEASE PRINT)	2. BIRTH DATE MO DAY YEAR	3. SOCIAL SECURITY NO. / /
4. ADDRESS ☐ CHECK HERE IF NEW ADDRESS CITY STATE ZIP		5. PHONE NO. ( )
6. EMPLOYER (Or Company you work for)		
6 a. ADDRESS CITY STATE ZIP		7. PHONE NO. ( )

8. IS DISABILITY DUE TO A WORK-RELATED CONDITION? ☐ YES ☐ NO	**9. IS THIS CLAIM FOR A NON-WORK-RELATED ACCIDENT OR INJURY?** ☐ YES ☐ NO
10. WHERE DID THE INJURY OCCUR?	**11. WHEN DID THE INJURY OCCUR?** MO DAY YEAR

12. BRIEF DECRIPTION OF HOW THE INJURY OCCURRED:

13. NAME AND CONTACT INFORMATION OF PERSON RESPONSIBLE FOR INJURY:

14. RESPONSIBLE PERSON'S INSURANCE INFORMATION:

15. EMPLOYEE STATEMENT AND AUTHORIZATION TO RELEASE INFORMATION:

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete. I hereby authorize any physician or any hospital to furnish and disclose all known facts concerning this disability. I will reimburse the fund for any overpayment made to me or in my behalf due to error on this form. I understand that it is a federal crime, punishable by fine or imprisonment, or both, to knowingly make false statements on this benefit claim form.

Employee Signature ____________________ Date ____________________

PART B PHYSICIAN'S STATEMENT OF DISABILITY *(MUST BE COMPLETED BY PHYSICIAN)*

1. PATIENT'S NAME: (PLEASE PRINT)		2. SOCIAL SECURITY NUMBER / /
3. ICD.10 CODE WITH DESCRIPTION:		4. IF DIAGNOSIS IS PREGNANCY, PLEASE LIST DUE DATE:
5. DATE PATIENT DISABLED FROM WORK:	6. DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK: (REQUIRED)	7. DATE PATIENT RELEASED TO RETURN TO WORK:
8. DATES PATIENT WAS FIRST SEEN FOR THIS DISABILITY:		IS THIS A SCHEDULED SURGERY? ☐ YES ☐ NO IF YES, PLEASE PROVIDE THE DATE:
9. FEDERAL TAX ID NUMBER:	10. PHONE NUMBER:	11. FAX NUMBER:
12. PHYSICIAN NAME: (PRINT)	13. PHYSICIAN CREDENTIALS: (PRINT)	14. DATE:
15. PHYSICIAN'S ADDRESS:		16. PHYSICIAN'S SIGNATURE